St. Luke's Physical Therapy
Morristown · 423-586-6866
Newport · 423-248-3240
Kingsport · 423-276-5431
Greeneville · 423-525-4148

St. Luke's Physical Therapy

PATIENT INFORMATION

Last Name:_____ First Name: _____ M. I.:____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone No.: _____ Mobile No.: _____

Email: _____ Sex : ☐Male ☐Female

Date of Birth: _____ Age: _____ Marital Status: _____

Social Security No.: _____

Emergency Contact.: _____ Phone No.: _____

Referring Physician: _____

Are you currently receiving home health or treatment from a skilled nursing facility?

☐Yes ☐No

PRIMARY INSURANCE COVERAGE	
Employer / Guarantor (if minor):	
Employer / Guarantor Phone No.:	
Insurance Company:	
Insured's Name:	
Insured's Date of Birth:	
Insured's S.S. No.:	
Insured's Relationship to Patient:	

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SECONDARY INSURANCE COVERAGE	
Insurance Company:	
Insured's Name:	
Insured's Date of Birth:	
Insured's Name:	
Insured's S.S. No.:	
Insured's Relationship to Patient:	

When is your next scheduled doctor's appointment?
(Doctor who referred you to St. Luke's Physical Therapy) _____

How were you reffered to St. Luke's Physical Therapy?

☐Doctor_____ ☐Family_____ ☐Friend _____

☐Newspaper ☐Radio ☐Yellow Pages ☐Google Search ☐Social Media ☐Others _____

Do you have social media accounts? Please check all that apply.

☐Facebook ☐Instagram ☐Others _____

I certify the demographics and insurance information provided above are current and accurate to the best of my knowledge. I understand that if there are any denials of payment from my insurance company due to my failure to update St. Luke's Physical Therapy of any changes in my insurance or failure to provide a copy of my insurance card(s), that I am responsible for payment of services.
I authorize the release of any medical or other information necessary to process my claims.
I authorize payment of medical benefits to St. Luke's Physical Therapy for services rendered to me.

Due to economy induced, financial restraints, we will be glad to discuss any financial concerns you may have.

_____ _____

Signature of Patient / Financially Responsible Party **Date**

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PATIENT'S NAME: _____

HEIGHT:		WEIGHT	

What is your usual activity/ exercise routine?		Days / Week		Minutes / Day
When was the last time you saw your primary care doctor?				

PAST AND CURRENT MEDICAL CONDITIONS			
☐	**Neurological:** MS, stroke or TIA, neuropathy, dementia / Alzheimer's, seizures	☐	**Hormonal:** Diabetes; If yes, how long? _____; Recent A1C _____; thyroid disorder, osteoporosis
☐	**Heart and Circulation:** High/Low Blood Pressure, heart attack/angina, poor circulation, high cholesterol, arrhythmia, congestive heart failure, syncope, drop attack	☐	**Genital and Urinary:** Prostate, gynecological conditions, urinary retention, frequency, loss of control of bowel or bladder, impotence
☐	**Digestive:** Hepatitis/cirrhosis, irritable bowel, reflux, ulcer/G.I. bleeding, kidney disease, heartburn or indigestion, food intolerances	☐	**Blood:** Anemia, sickle cell disease, blood clot, immune suppression HIV/AIDS, bleeding disorder
☐	**Breathing:** COPD/emphysema, tuberculosis, asthma, sleep apnea	☐	**Cancer:** *(Please describe, including surgeries)* _____
☐	**Substance usage:** caffeine, alcohol, tobacco, recreational drugs	☐	**Arthritis:** Lupus, rheumatoid, arthritis/osteoarthritis
☐	**Surgical History:** *(use a separate sheet if necessary)*	☐	**Other surgeries or conditions:** _____ _____
☐	**Implanted Electronic Device**	☐	

CURRENT HEALTH • In the past three (3) months, have you had or do you experience:			
☐	Fatigue or malaise	☐	Numbness, tingling or genital area numbness
☐	Fever / chills / sweat / infection	☐	Bowel or bladder problems
☐	Nausea and/or vomitting	☐	Problems with cognition / thinking

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☐	Swelling in your arms or legs	☐	Dizziness / lightheadedness
☐	Unexplained weight change	☐	Reduction in balance, coordination and/or walking
☐	Extremity weakness	☐	Loss of consciousness, syncope, drop attacks
☐	Shortness of breath or difficuilty in breathing	☐	Difficuilty swallowing or speaking
☐	Change of appetite	☐	Frequent coughing
☐	Chest pain / irregular heart rate / palpitations	☐	Falls *(How many in the past year?)*
☐	Implanted Electronic Device	☐	_____

Do you have difficuilty hearing in noisy environments such as a restaurant or party?	☐Yes ☐No
Do family members think you have difficuilty hearing?	☐Yes ☐No
During the past month, have you often been bothered by feeling down, depressed or hopeless?	☐Yes ☐No
During the past month, have you often been bothered by little interest or pleasure in doing things?	☐Yes ☐No
Is it something with which you would like help?	☐Yes, today ☐Yes, but not today ☐No
What other providers do you treat with?	☐Chiropractor ☐ENT ☐Orthopedist ☐Neurosurgeon ☐Psychologist / Psychiatrist ☐Pain Management ☐Other *(Please specify:_____)*

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Please list your medications:

Name	Frequency	Route taken (Oral / Injection)	Dosage

Do you take blood thinners?	☐Yes ☐No
Have you taken steroids fo an extended period of time *(more than three months)*?	☐Yes ☐No
Please list any diagnostic tests regarding your current problem *(MRI, Xray, VNG/ENG, etc.)*	
What is your primary reason for coming to P. T.?	
What date *(approximate)* did your symptoms start?	
What do you think caused your symptoms?	
What are your expectations for care?	
What are your goals for therapy?	
Are your symptoms: *(please check one)*	☐Worsening ☐Staying the same ☐Improving

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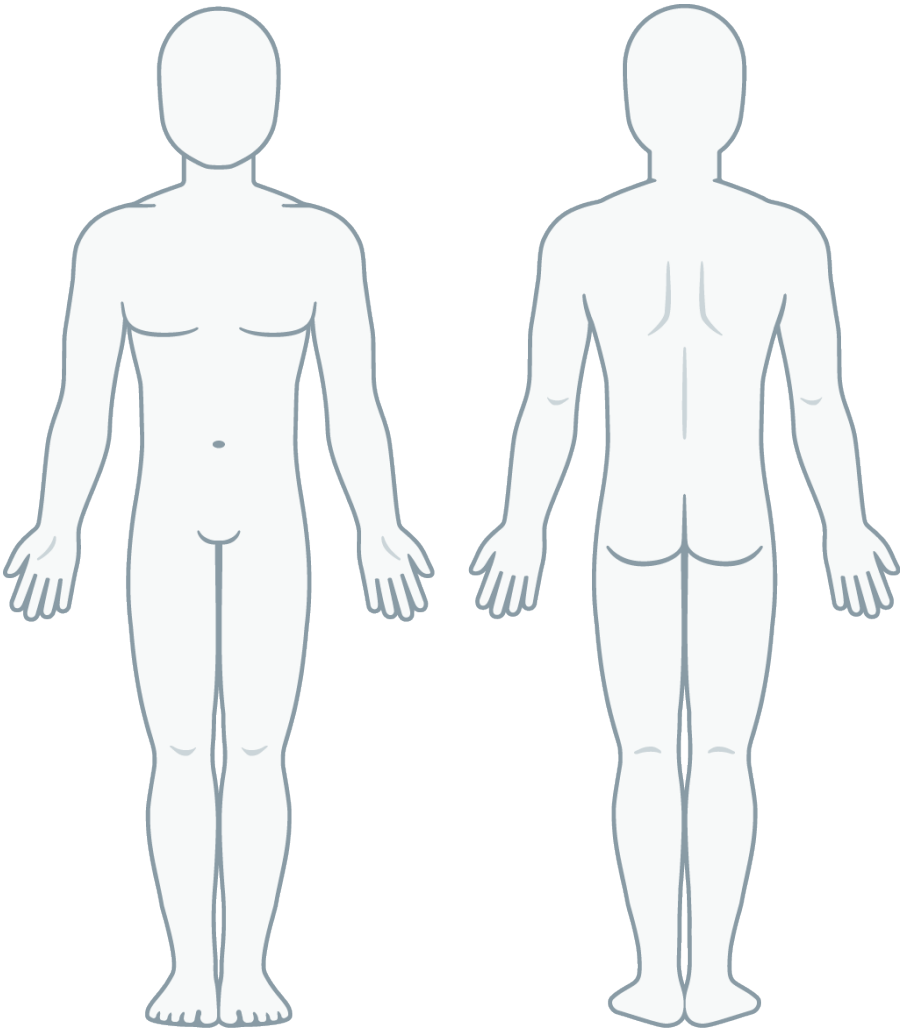
PAIN DIAGRAM

Please mark the areas where you feel pain



Symptom Average for the last 48 hours:												
NO PAIN	0	1	2	3	4	5	6	7	8	9	10	**WORST IMAGINABLE PAIN**
Worst for the last 48 hours:												
NO PAIN	0	1	2	3	4	5	6	7	8	9	10	**WORST IMAGINABLE PAIN**
Best for the last 48 hours:												
NO PAIN	0	1	2	3	4	5	6	7	8	9	10	**WORST IMAGINABLE PAIN**

PATIENT NAME: _____ **DATE OF BIRTH:** _____

COMPASSIONATE CARE • EXCELLENT RESULTS

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CONSENT TO CALL

As a service to our patients, we routinely phone you the day before your appointment as a reminder to you. Confidentiality regulations require that we obtain your written consent to be contacted. It may also be necessary for the front office personnel or physical therapist, to contact you regarding important information regarding your health.

I agree you may leave a message on my answering machine or with a family member.

SIGNATURE: _____ **DATE:** _____

APPOINTMENT / SCHEDULING PROTOCOL

1. All patients are to contact our office within **24 hours** (if at all possible) of their scheduled appointment to **CANCEL** or **RESCHEDULE** appointments.
2. For your appointments, please check-in with the front office personnel. The front desk staff will let the physical therapist know you are here. **We ask that you PLEASE WAIT in the LOBBY until notified otherwise by your physical therapist.** This will provide others with their full appointment time.
3. For optimal results, you need to be compliant with the therapy program(s) recommended by your physician and physical therapist.
4. Please notify your physical therapist immediately if any changes occur in your current status (i.e. diagnosis, signs, symptoms, physician, insurance, etc.)
5. We strive to be flexible as possible with appointment times and rescheduling; however, if you are fifteen **(15) minutes late, you will need to call our office as you may need to reschedule your appointment.**
6. **Failure to show for three (3) consecutive, unexcused appointments may result in discontinuation of therapy with notification of non-attendance forwarded to your physician, insurance and/or case manager.**

If you have any concerns or questions during your therapy experience, please discuss them with your physical therapist. We hope the time you spend with us will be beneficial to you and your recovery!

SIGNATURE: _____ **DATE:** _____

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PRIVACY PRACTICES

☐ Patient received a copy of the Notice of Privacy Practices

☐ Good faith efforts were made to obtain patient's acknowledgement of receipt of the Notice of Privacy Practices but the acknowledgement was not obtained because: _____

_____

_____

☐ It was not possible to obtain a copy of the patient's acknowledgement of receipt of the Notice of Privacy Practices because of an emergency treatment situation. If you consent, the office is permitted by federal privacy laws to make uses and disclosure of your health information for purposes of treatment, payment, and healthcare operations.

Protected health information is the information we create and obtain in providing our services to you. Such information may include documentation of your symptoms, examinations and test results, diagnoses, treatments, and applying for future care treatment. It also includes billing documents for those services.

Examples of your health information for treatment purposes are:

☐ A therapist obtains treatment information about you and records it in a health record.

☐ During the course of your treatment, the therapist determines he will need to consult with another specialist in the area. He will share the information with such specialist and obtain his/her input.

Examples of your health information for payment purposes are:

☐ We submit a request for payment to your insurance company. The health insurance company or business associate helping us to obtain payment requests information from us regarding your medical care given. We will provide information to them about you and the care given.

Examples of your health information for Health Care Operations:

☐ We may obtain services from business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review, legal services and insurance. We will share information about you with such business associates as necessary to obtain these services.

Patient acknowledges receipt of the Notice of Privacy Practices and agrees that the office of St. Luke's Physical Therapy may use and disclose the Patient's protected health information as described above.

SIGNATURE: _____ **DATE:** _____

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PATIENT NOTIFICATION REGARDING COVID-19 PRECAUTION

In order to ensure your safety, other patient's safety, and our staff's safety, we would like for each of our patient to check their temperature prior to each attendance to each visit. If your temperature is at least 100.4*F (38*C) or greater, we advise you to notify us by phone and subsequently cancel your visit. Contact your primary care physician and follow their instructions. We will also check your temperature at the door as you come in. We also urge you to stay home and cancel your Physical Therapy appointment for other corona virus infection symptoms along with the fever which include: cough and shortness of breath, or digestive issues such as diarrhea. Other symptoms they have recently mentioned are the loss of sense of smell and taste for early stage of infection. Please avoid crowded places and observe social distancing.

We are very eager to continue our services in this trying time, but also would like to ensure the utmost care and precaution we could provide.

We will continue to do our part in keeping our facility in good sanitary condition and follow CDC guidelines.

Hoping for your kind consideration and understanding regarding this matter. Please let us know if we could be of any assistance during these times. Please sign below to acknowledge Notification of Agreement

_____
Name of Patient

_____ _____
Signature of Patient **Date**